Rights & Responsibilities

A guide to the Mental Health Act

Ministry of Health
Ontario


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This booklet has been prepared as a guide to the Mental Health Act.

For detailed information about the Act, please refer to the legislation.

Additional copies of this booklet, free of charge, and copies of the consolidation of the Act at nominal cost, are available from the Ontario Government Bookstore, Mail Order Service, 5th floor, 880 Bay Street, Toronto, Ontario M7A 1N8; (416) 965-6015.

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ABOUT THE ACT

Mental illness is a major health problem in Canada. Statistics indicate that a high proportion of people will, at some point in their lives, require hospitalization because of mental disorder.

It is, therefore, essential to have a Mental Health Act that gives clear guidance for everyone concerned with the fair and equal treatment of those who need mental health care.

Fortunately, in our society today, much of the "fear of the unknown" has disappeared from our treatment of the mentally ill. We have come a long way from the days when the mentally ill were simply "put away", out of sight and out of mind.

Many changes in mental health services

In the past 35 years, vast changes in the delivery of mental health services have taken place. For example:

- modern chemotherapy was introduced, including the major anti-psychotic and anti-depressant drugs;
- the philosophy of treatment in the community, with hospitalization as a last resort, has reduced the numbers of patients in our psychiatric institutions by two-thirds;
- services were developed in the community where the patient lives; for example, psychiatric services are now offered in 69 general hospitals across Ontario, out-patient services are offered by provincial psychiatric hospitals and a wide range of community support services have been developed;
- new treatment programs and support services offered include rehabilitation services, day care, counselling services, residential accommodation, approved homes, sheltered workshops and volunteer programs;
- the Ministry of Health funds Patient Advocates in the 10 provincially operated psychiatric facilities who function to protect patients' rights;
- Rights Advisors have been established in all psychiatric facilities to advise patients of their rights regarding involuntary committal and incompetency.

In recent years, the number of people treated for psychiatric problems on a voluntary basis has increased enormously. Today, 75 per cent of those in Ontario's psychiatric hospitals are voluntary patients. Much of this increase can be attributed to the growing recognition of mental illness for what it is — an illness like any other illness.

Advances in treatment that make improvement possible and easier, together with a better understanding of mental illness, are

clear indications of progress toward better control and alleviation of mental illness.

Changes in attitude and treatment methods were reflected in major amendments to the Mental Health Act in 1978.

The Act was further amended in 1986, to bring it into compliance with *The Charter of Rights and Freedoms*, and amended again in June 1987, in regard to treatment and substitute decisionmaking. These areas are highlighted in this Guide.

1. CIVIL COMMITTAL AND INVOLUNTARY ADMISSION

Role of the physician

When and why a physician may make an application for psychiatric assessment (Form I)

The Act states that:

"Where a physician examines a person and has reasonable cause to believe that the person,

a) has threatened or attempted or is threatening or attempting to cause bodily harm to himself;
b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him; or
c) has shown or is showing a lack of competence to care for himself",

and if in addition, the physician "is of the opinion that the person is apparently suffering from mental disorder of a nature or quality that likely will result in,

d) serious bodily harm to the person;
e) serious bodily harm to another person; or
f) imminent and serious physical impairment of the person;

the physician may make application, in the prescribed form, (Form 1), for a psychiatric assessment of the person".

The criteria for assessment are the same as the criteria for committal. They describe the nature of the evidence required

and the grounds for action by a physician.

The Act gives a physician latitude in forming an opinion based on his or her belief, either through his or her observations, or on the basis of facts revealed by others. On the Form 1, however, it must be clearly indicated which facts were observed by the physician and which were observed by others.

It is important to emphasize that a physician need not be certain that "serious bodily harm" will result before he or she acts. This is very much a judgment call, as indicated by the word "opinion" in the Act.

The physician is asked to determine whether a person is "apparently" suffering from a mental illness which is "likely" to result in serious physical harm to the patient or another, or in serious and imminent physical impairment of the patient, if the person is not hospitalized.

The Application for Psychiatric Assessment (Form 1) must state that the physician who signs it personally examined the person and made careful inquiry into all the facts necessary to form his or her opinion of the nature and quality of the mental disorder. It must be dated.

The physician's Application for Assessment (Form 1) must be signed within seven days after the initial examination. This emphasizes the need to act quickly where a serious threat exists. For seven days after the physician has signed it, the application is sufficient authority for any person to take the subject of the application in custody to a psychiatric facility, to detain the person in the facility, and to restrain, observe and examine the person there for not more than 72 hours.

The statute uses the words "take in custody" to clarify the authority of the application to provide for the use of reasonable force to take a person to a psychiatric facility if that person refuses to go voluntarily.

When the person is taken to the facility on the basis of an Application for Assessment, an assessment is performed. Based on the results of the assessments the facility may admit the person as an informal, voluntary or involuntary patient, depending upon the circumstances, and whether the committal criteria are met. After the assessment is complete, the attending physician must release the person if he/she is of the opinion that the person is not in need of psychiatric treatment.

Involuntary committal

The opinion of a physician other than the physician who completed the Form 1, must be obtained during the 72 hour period if the patient is to be detained as an involun-

tary patient. The second physician completes a Certificate of Involuntary Admission (Form 3), which is then sufficient authority to detain the person further, for a period of up to two weeks. The second physician must be of the opinion that the person is suffering from a mental disorder "of a nature or quality that likely will result in serious bodily harm to the person, or to another person, or imminent and serious physical impairment of the person", unless the person remains in the custody of the psychiatric facility, *and* that the person is not suitable for admission as an informal or voluntary patient.

The physician who completes the Certificate of Involuntary Admission must not be the same physician who completed the Application for Psychiatric Assessment.

The requirement for a "second opinion" ensures that no person will be admitted as an involuntary patient unless the appropriate criteria are identified by at least one physician in a psychiatric facility.

Release of person by officer in charge

The officer in charge of the psychiatric facility has the obligation to release the person after 72 hours — unless the attending physician has already done so, or has admitted the person as a voluntary or informal patient, or completed a Certificate of Involuntary Admission.

The physician must notify the patient that the involuntary committal has been made, the reasons therefor and the fact that the patient has a right to retain counsel without delay, in order to contest the committal.

As is discussed in greater detail later, a patient may challenge this involuntary committal before the Review Board.

Certificates of renewal for periods of committal

If an attending physician in a psychiatric facility wishes to keep a patient hospitalized involuntarily after the 14 day period permitted under a Certificate of Involuntary Admission (Form 3), he or she must complete a Certificate of Renewal (Form 4).

The criteria for completing a Certificate of Renewal (Form 4) are the same as those for involuntary committal under a Form 3. The attending physician must assess the patient again to ensure that the patient continues to meet the committal criteria before the Form 4 can be signed.

An involuntary patient may be "detained, restrained, observed and examined" in a psychiatric facility beyond the initial 2 week period for not more than one additional month under a first Certificate of

Renewal; two additional months under a second; and three additional months under a third or subsequent certificate.

This system ensures frequent access to the Review Board for a review of a patient's committal status because a patient has the right to a review hearing each time a new certificate is executed by his or her attending physician. In other words the Form 3 and each Form 4 can all be reviewed.

A patient's status is automatically reviewed by the Review Board on the completion of a fourth certificate of renewal and on the completion of every fourth certificate of renewal thereafter, even if the patient does not ask for a Review Board hearing. The right to this automatic review cannot be waived.

Change from involuntary to voluntary status

If a certificate of involuntary admission or certificate of renewal expires, and no subsequent certificate is executed by the attending physician, the patient is deemed to be a *voluntary* patient.

At any time, the attending physician may change the status of an involuntary patient to that of voluntary patient (Form 5).

Conversely, the status of a patient who is an informal or voluntary patient may be changed to involuntary if the committal criteria are met and the attending physician signs a certificate of involuntary admission.

Other types of admission

Voluntary admission

Any person believed to be suffering from a mental disorder such that the person is in need of the treatment provided in a psychiatric facility may be admitted as a voluntary patient on the recommendation of a physician at a psychiatric facility. A voluntary patient may leave the facility any time he or she wishes.

Informal admission

A person who is under the authority of a parent, a guardian, or a committee of the person appointed under the *Mental Incompetency Act* may be admitted as an informal patient if the attending physician is of the opinion that the person is suffering from a mental disorder such that the person is in need of the treatment provided in a psychiatric facility.

Persons detained under the Criminal Code

The Act also states that any person who, under the *Criminal Code* of Canada, is remanded to custody for observation or detained under authority of a Warrant of the Lieutenant Governor, may be admitted to,

detained in, and discharged from a psychiatric facility in accordance with the law.

Role of the Justice of the Peace

When and why an order for psychiatric examination may be made

A Justice of the Peace can make an order for a psychiatric examination of a person by a physician based on information before him or her, where there is reasonable cause to believe that the person is apparently suffering from a mental disorder and satisfies the other criteria. The Justice of the Peace issues such an order on the basis of *sworn* information, contained in an affidavit. Neighbours, relatives and others who might not be able to proceed by having a physician sign the Application for Assessment, have this option, if a person is in need of psychiatric care.

The Act states that "where information, upon oath, is brought before a Justice of the Peace that a person within the limits of his jurisdiction,

a) has threatened or attempted or is threatening or attempting to cause bodily harm to himself;
b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him; or
c) has shown or is showing a lack of competence to care for himself;

and in addition, based upon the information before him, the Justice of the Peace has reasonable cause to believe the person is apparently suffering from mental disorder of a nature or quality that likely will result in,

d) serious bodily harm to the person;
e) serious bodily harm to another person; or
f) imminent and serious physical impairment of the person,

the Justice of the Peace may issue his Order (Form 2), for the examination of the person by a physician".

A Justice of the Peace is not required to make a medical diagnosis. Based on the evidence supplied by way of sworn information, the Justice must believe, on reasonable and probable grounds, that the individual described is apparently suffering from mental disorder and that the rest of the criteria are met. Once the Justice has formed this belief, he or she may order the individual to be taken to an appropriate place (a health facility, where possible) for the initial examination by a physician.

It is important to recognize that the result of this order will be to gain a medical opinion; it is not in itself sufficient authority to detain a person any longer than necessary for the initial examination.

Seven day authority for constable or peace officer

The Order for Examination (Form 2) is sufficient authority for seven days for any constable or peace officer, to whom it is addressed, to take the person named or described in the order "in custody forthwith" to "an appropriate place where he may be detained for examination by a physician". This must be conducted promptly.

Only the Form 1 issued *following* this examination by the physician is sufficient authority to detain the person in a psychiatric facility for up to 72 hours.

Where practicable, the place of examination will be a psychiatric or other health facility.

Role of the police

Under the Act, where a constable or other peace officer observes a person who acts in a manner that in a normal person would be disorderly, and has reasonable cause to believe that the person,

"a) has threatened or attempted or is threatening or attempting to cause bodily harm to himself;

b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him; or

c) has shown or is showing a lack of competence to care for himself,

and in addition the constable or other peace officer is of the opinion that the person is apparently suffering from mental disorder of a nature or quality that likely will result in,

d) serious bodily harm to the person;

e) serious bodily harm to another person; or

f) imminent and serious physical impairment of the person."

and when circumstances of the case make it dangerous to wait until an Order for Examination is obtained from a Justice of the Peace, the constable or other peace officer may take the person in custody to an appropriate place for an immediate initial examination by a physician. This provides an alternative to the constable or peace officer to laying a charge.

Again, only the Form 1 issued *following* this initial examination by a physician is sufficient authority to detain the person for up to 72 hours for a complete psychiatric assessment and, where practicable, the place of initial examination must be a psychiatric or other health facility.

The grounds for action by a peace officer coincide with the criteria utilized by physicians and Justices of the Peace. In addition, the peace officer must *observe* behaviour that in a normal person would be

disorderly. It is not sufficient that a person's acts be *reported* to the police.

Constable's duty at facility

The Act stipulates that a constable, or other peace officer, or anyone else who takes a person in custody to a psychiatric facility shall remain there and retain custody until the facility accepts custody of the person. This does not necessarily require the peace officer or other person to remain until the person is admitted. Once custody is accepted by the facility, the peace officer or other person may depart.

Because of the potential danger involved in abandoning an individual in certain instances, this obligation reflects the desirability of a peace officer's continued presence. The peace officer's duty is to remain until effective control of the person has been transferred to the facility.

Role of the judge

If a judge has reason to believe a person who appears before him charged with, or convicted of, an offence is suffering from mental disorder, the judge may issue an Order for Attendance for Examination (Form 6), which will require the person to attend a psychiatric facility for examination.

A judge may remand any person in custody, who appears before him charged with an offence, through an Order for Admission (Form 8) for admission as a patient to a psychiatric facility for a period of not more than two months.

2. GENERAL ISSUES OF CONCERN

Communication to and from patients

The general rule is that no communication written by a patient or sent to a patient shall be opened, examined or withheld, and its delivery shall not in any way be obstructed or delayed.

This general rule applies unless the officer in charge of the facility, or a person acting under the officer's authority, has reasonable and probable cause to believe that the contents of a communication written by a patient would prejudice the patient's best interests, or be unreasonably offensive to the person receiving it, or that the contents of a communication sent to a patient would interfere with the patient's treatment or cause the patient unnecessary distress.

In such circumstances, the officer in charge of the facility, or a person acting under the officer's authority, may open and examine the contents of the communication. If any of the above conditions exist, the officer may withhold such communication from delivery.

Under no circumstances, however, may a communication be opened that is written by a patient to a barrister and solicitor, the Ombudsman, a member of a Review Board, or a member of the Legislature. Similarly, communications from any of those people to a patient may not be opened.

Leave of absence — three month limit

Unless a patient is subject to detention other than under this Act, the officer in charge may — upon the advice of the attending physician — place the patient on "leave of absence" from the psychiatric facility, upon such terms and conditions as the officer in charge may prescribe, for a designated period of not more than three months.

Unauthorized absence of a patient

Where a person who is subject to detention is absent without leave from a psychiatric facility, a constable or other peace officer — or anyone appointed by the officer in charge — may return the person to the psychiatric facility or take the person to the facility nearest the place of apprehension.

After the person's absence has become known to the officer in charge, a constable may act without an order signed by the officer in charge for the first 24 hours and for up to one month under the authority of an Order for Return (Form 9) signed by the officer in charge of the facility.

Where a patient is absent without leave for a one month period after his absence became known to the officer in charge, the patient is deemed to be discharged from the facility.

Transfer of patients

The Act permits transfers of a patient from one facility to another, or to a public hospital for medical treatment, or to an institution outside Ontario (if the patient's hospitalization is the responsibility of another jurisdiction), or in the patient's best interests, upon the advice of the attending physician.

If a patient requires hospital treatment that cannot be obtained in a psychiatric facility, transfers to public hospitals for the purpose of receiving such treatment can be arranged.

Mentally ill persons coming into Ontario

Where the Minister of Health has reason to believe there may come or be brought into Ontario a person suffering from mental disorder of a nature or quality that likely will result in serious bodily harm to the person, or to another person unless that individual is placed in the custody of a psychiatric facility, the Minister may authorize anyone to take the person in custody to a facility.

The order (Form 13) is also authority to admit, detain, restrain, observe and examine the person there for up to 72 hours.

This provision is most often used where Ontario residents, detained in facilities outside the province, are returned to Ontario.

The patient must be notified of the fact that such an order has been made, the reasons therefor and the fact that he or she has the right to retain and instruct counsel without delay.

Restraint

The Act provides for the restraint of persons on Forms 1, 3 and 4 to prevent serious bodily harm to the patient or to someone else. No consent is required. However, numerous safeguards exist; e.g., only minimal measures of intervention can be used as are reasonable in the circumstances. In addition, extensive documentation is required under the Act.

Mental competence

There are four main kinds of mental competence described in the Mental Health Act. Patients must generally be mentally competent before they are authorized to make decisions in important areas affecting their care within a psychiatric facility. Where the patient is not mentally competent, there is a mechanism established to provide for substitute consent. The four main areas include mental competence to consent to treatment; to permit disclosure of the patient's clinical record; to gain access to the patient's clinical record; and to manage one's estate.

Any patient found by a physician to be mentally incompetent in regard to any of these matters has a right to appeal that finding to the Review Board and ultimately to the court. In addition, the presumption that a person under 16 years of age is not mentally competent to consent for certain purposes can also be challenged.

"Mentally competent" is defined in the Mental Health Act as "having the ability to understand the subject-matter in respect of which consent is requested and able to appreciate the consequences of giving or withholding consent." When considering the specific issue of consent to treatment, "having the ability to understand the subject matter in respect of which consent is requested" is further defined to mean "having the ability to understand the nature of the illness for which treatment is proposed and the treatment proposed."

3. TREATMENT

Competent patients

Every patient — voluntary, involuntary or informal — has the right to have psychiatric treatment available and the right to expect that all his or her rights will be respected. Any patient — voluntary or involuntary — who is competent to make a treatment decision may refuse treatment at any time. That refusal must be honoured by the psychiatric facility.

Incompetent patients

A treatment decision on behalf of a patient who is determined by the attending physician to be incompetent to make treatment decisions can be made with the consent of the proper substitute consent-giver. As is discussed below, patients have the right to appoint their own representatives to make decisions, including treatment decisions, on their behalf if they become incompetent.

Note that the attending physician's finding of incompetence to make a treatment decision is reviewable by the Review Board at the patient's request. (Notice of such finding is provided to the patient.)

A substitute consent-giver, when giving or refusing consent to treatment, must *first* consider the wishes of the patient if the consent-giver knew what those wishes were when the patient was competent.

If the substitute consent-giver does not know what those wishes were, the best interests of the patient must be considered.

A substitute consent-giver must consider the following factors to determine whether a specific psychiatric treatment is in the best interests of the patient before deciding to consent to, or refuse the treatment:

a) will the mental condition of the patient be or likely be substantially improved by the treatment;
b) will the mental condition of the patient improve or likely improve without the psychiatric treatment;
c) will the anticipated benefit from the psychiatric treatment outweigh the risk of harm to the patient;
d) will the psychiatric treatment be the least restrictive and least intrusive treatment that meets the above three requirements.

Where the life, limb or vital organ of a patient is at risk, the Act provides for the provision of emergency psychiatric and other related medical treatment without consent.

Treatment orders

A physician may apply to the Review Board for an order to treat an *incompetent, involuntary* patient only where the substitute decision-maker refuses to consent to treatment, or where two people who purport to be the consent-givers disagree as to whether to consent to treatment. A physician may also apply for an order to treat *incompetent* patients who are detained under Warrants of the Lieutenant Governor, but who *also* meet the committal criteria, and whose substitute consent-givers either refuse to consent to treatment or disagree as to consent. Treatment orders are only granted under certain controlled circumstances and the Review Board's order can be appealed to the District Court.

Electroconvulsive therapy cannot be ordered by a Review Board under any circumstances.

The four criteria listed above which substitute consent-givers must consider in applying a "best interests" test must also be considered by the Review Board on an application for a treatment order. The Review Board can only authorize the giving of treatment if it is satisfied that those four criteria have been met.

In support of an application for a treatment order, there must be the opinion of both the attending physician *and* a psychiatrist who is not a member of the medical staff of the particular psychiatric facility, that each of the four criteria listed above are met in relation to the specified psychiatric

treatment for which the physician is applying.

A patient for whom a treatment order is sought can also challenge both the involuntary committal and the finding that he or she is incompetent to make a treatment decision. Patients under 16 are *presumed* incompetent but they can challenge this presumption at a Review Board hearing.

Review Board orders concerning treatment can be appealed to court.

4. CONFIDENTIALITY OF PSYCHIATRIC RECORDS

The general rule is non-disclosure

According to the Act, the general rule is that, with certain exceptions, no person shall disclose, transmit or examine the clinical record compiled in a psychiatric facility in respect of a patient.

The Act's provisions respecting confidentiality do not apply to professionals in private practice. Other legal sanctions (e.g. the Health Disciplines Act) and in general, professional ethics, require all physicians to keep confidential anything disclosed to them by their patients. Improper disclosure constitutes professional misconduct.

Permissible exceptions

Under the Act, the officer in charge and the attending physician at the psychiatric facility in which a clinical record is prepared may examine the record, and the officer in charge *may* disclose or transmit it to, or permit its examination by:

- any person, with the patient's consent, where the patient is mentally competent;
- any person, with the consent of the appropriate substitute consent-giver, where the patient is not mentally competent;
- any person employed in or on the staff of a psychiatric facility, for the assessment or treatment of the patient;
- the chief executive officer of a health facility currently involved in the direct

health care of the patient, on written request to the officer in charge;
- any person currently involved in the direct health care of the patient in a health facility, where delay in obtaining consent would endanger the patient's life, a limb or a vital organ; or
- any person, for the purpose of research, academic pursuits, or the compilation of statistical data on the condition that if the record is to be used outside the psychiatric facility, the patient's name and any other means of identification of the patient is removed.

In summary, disclosure may be made in most situations only with the consent of patients or their appropriate substitute consent-giver.

The exceptions cover hospital staff involved in the patient's treatment. They include the administrator of another facility currently treating the patient. This is particularly important for provincial psychiatric hospitals, since individuals are often transferred to other facilities and suitable provision must be made for appropriate information to accompany them.

In emergencies, too, disclosure is permissible to anyone in a health facility who is currently involved in the care of a patient.

Disclosure in court

The public interest in the treatment of mentally disturbed patients requires that communication during their examination should be "privileged". A patient's belief in the complete confidentiality of communications made to mental health workers has a significant effect on the frankness of disclosure and on the effectiveness of treatment.

Current psychiatric hospital practice reflects the development of treatment teams that require all members to contribute to the facility record. To be forced to reveal this information could have an injurious effect on the overall treatment, could result in a breakdown in the staff-patient relationship, and could undermine the confidence patients and their families have in the facility.

The Act directs the officer in charge of a psychiatric facility to disclose, transmit or permit the examination of a clinical record pursuant to a subpoena, order, direction, notice or similar requirement in respect of a matter that is or may be an issue in a court of competent jurisdiction or pursuant to specific access provisions under this or any other Act.

However, if the attending physician is of the opinion that this disclosure is likely to harm the treatment or recovery of the patient, or harm a third person physically or

mentally, the physician is to protect the records from disclosure. On appeal to court by the person seeking the record, the court will not order disclosure unless satisfied that to do so is essential in the interests of justice.

Further, any person in a psychiatric facility who obtains information about a patient in the course of his or her duties, may disclose this information in court only with the consent of the patient or the patient's substitute consent-giver, unless the court orders that such disclosure is essential in the interests of justice.

The above provisions do not apply to mental health professionals in private practice unrelated to a psychiatric facility.

Patient's own access

A patient who is mentally competent is entitled to examine and copy at his or her own expense his or her clinical record. A Form 28 must be completed by the patient to make a formal request for disclosure.

With few exceptions, the patient *shall* be allowed to examine or copy the record. The exception exists where, within 7 days of the patient's request, the officer in charge (on the advice of the attending physician) applies to the Review Board for authority to withhold all or part of the record because the physician believes that disclosure of the record is likely to result in:

a) serious harm to the treatment or recovery of the patient *while in the facility*; or
b) serious physical or emotional harm to another person.

It is clear that former patients and out-patients also have this right of access.

Where the patient believes the record is wrong

The Act specifically permits a patient to request a correction where, in the opinion of the patient, the record is in error or there is an omission. Where the request is not granted, the patient may require that a "statement of disagreement" be attached to the clinical record, reflecting the changes that the patient requested.

The issue of competence

A patient may challenge before the Review Board the finding that he or she is incompetent to either examine or permit the disclosure of the clinical record. Patients under age 16 are *presumed* incompetent but they can challenge this presumption at a Review Board hearing.

A prescribed consent form must be used

Where records are released under the

authority of a consent, the form of that consent is not left to the discretion of individual psychiatric facilities.

The designated consent forms (Forms 14 or 28) now required are provided in the regulations of the Act. They require, among the information to be included, the identity of the facility in possession of the clinical records, and of the person to whom the information is being made available.

A Form 14 must also be used when consent to disclosure of information is sought about patients in general hospitals whose primary care is psychiatric, where those hospitals are designated psychiatric facilities.

Use of records for research

The provisions require that where a clinical record is transmitted or copied for use outside the psychiatric facility "for the purpose of research, academic pursuits, or the compilation of statistical data", the officer in charge of the facility shall remove from the record the name of, and any means of identifying, the patient.

The person who examines the record shall not disclose the name of the patient or any means of identifying the patient.

5. SUBSTITUTE CONSENT-GIVING

In June 1987, the law concerning substitute consent changed substantially.

A patient who is competent to make a decision is legally the appropriate person to make that decision. Where a patient is not mentally competent to make a consent decision, the law requires that a substitute consent-giver or decision-maker make the decision on behalf of the patient. However, if the substitute decision-maker is not available and willing to make the decision and there is such an emergency that the patient's life, limb or vital organ is at risk, then treatment can proceed.

The law permits a person to appoint a personal representative to make decisions on his or her own behalf should he or she become incompetent to do so. The appointment of the representative must be in writing and must be made when the patient is competent. The substitute consent-giver must be at least 16 years of age, competent to make decisions and willing and available to do so. A person who appoints his or her own representative can revoke that appointment in writing.

If a patient is found to be incompetent to appoint a personal representative, the patient may apply to the Review Board to have a representative appointed. The person who the patient has chosen is a necessary party to such a hearing. The Review Board,

however, does not have to approve the patient's own choice.

The Act sets out the following list of potential substitute consent-givers:

i) the committee of the person appointed by a court under the *Mental Incompetency Act;*
ii) the patient's personal representative (as discussed above);
iii) the patient's spouse or common-law spouse (if certain tests are met);
iv) the patient's child;
v) the patient's parent (or guardian);
vi) the patient's brother or sister;
vii) any other next of kin of the patient;
viii) the Official Guardian.

The Act is clear that this list is in order of priority. In other words, if a child, (number four on the list) is available, willing and old enough to give consent, then that person's consent must be sought before that of the patient's brother or sister, (who appear as number six on the list). Similarly, the Act is clear that if two people of equivalent position, for example, two brothers, disagree as to whether consent should be granted, the refusal prevails, subject to Review Board override for involuntary patients.

The basis of consent

Most importantly, people who are authorized to give or refuse consent on behalf of a patient must do so in accordance with the wishes of the patient if the person knows what those wishes were when the patient was competent. If the person does not know what the patient's wishes were, the person must act in the best interests of the patient.

6. THE REVIEW BOARD

The Act provides for a Review Board to be established. Twelve panels of the Board sit across the province. Each panel is composed of at least one lawyer, one psychiatrist and one person who holds neither of those positions. The panels sit with three or five members. The Board acts in a quasi-judicial capacity.

Jurisdiction

The Act sets out numerous issues upon which the Board can be requested to make a ruling. In most cases, it is the patient who wishes some decision of a physician or psychiatric facility to be reviewed and, therefore, usually a patient commences the review proceeding. There are instances under the Act, however, where it is the physician or the psychiatric facility that may commence the hearing process.

The Review Board has the jurisdiction under the Act to do the following:

1. At the request of the patient —
   a) review the patient's involuntary committal (Form 3) into a psychiatric facility or the renewal of that involuntary committal (Form 4);
   b) review a finding that the patient is incompetent to make treatment decisions;
   c) review a finding that the patient is incompetent to examine his or her own clinical record, or permit its disclosure to someone else;
   d) review the presumption that a patient who is under age 16 is mentally incompetent to make a decision;
   e) appoint the patient a representative to be the patient's substitute decision-maker;
   f) review the need for a child between the ages of 12 and 15 to have observation, care and treatment in a psychiatric facility;
   g) review a finding that the patient is incompetent to manage his or her estate.

2. At the Request of the Attending Physician or Psychiatric Facility —
   h) consider a request to withhold part or all of a patient's record from disclosure under Section 29a(4);
   i) consider an application for an order to treat an involuntary, incompetent patient, or an incompetent patient under a Warrant of the Lieutenant Governor who meets the committal criteria where the substitute has refused consent.

3. Automatically —
   j) hear reviews of involuntary

committal upon the completion by the attending physician of a fourth certificate of renewal;

k) hear reviews of informal patients between the ages of 12 and 15 years to determine whether they need observation, care and treatment in a psychiatric facility at the end of six months after the patients' last review hearing or after admission.

The review mechanism can in some instances be initiated by the Minister of Health, the Deputy Minister, the officer in charge of the psychiatric facility, or someone other than the patient, but on the patient's behalf.

Procedure at the Review Board

Once a request for a hearing has been made by any person, the hearing must take place within seven days after the day the Review Board receives written notice of the request. This time can be extended if agreed to by all of the parties. Within one day after the Review Board completes its hearing, the Board must make a decision and inform all parties of that decision. Within two days from rendering the decision, the Board must provide to all parties the written reasons for the decision which was reached.

Prior to the hearing taking place, a party, or his or her solicitor, can examine and copy any written or documentary evidence that will be produced at the hearing.

Appeal Rights

With one exception, any decision of the Review Board can be appealed by any party to the District Court of the county or district in which the relevant psychiatric facility is located. An appeal must be commenced by Notice of Appeal within 10 days after the written reasons for the decision of the Board are provided to the party. The exception concerns the decision of the Board on application by the officer in charge for permission to refuse to disclose part or all of the clinical record to the person requesting it. There is no right of appeal of the Board's decision in that situation.

Appeals may be made on questions of law or fact or both. On an appeal, the District Court can substitute its opinion for that of the Review Board. The court can also send the matter back to the Review Board for a new hearing.

7. THE PUBLIC TRUSTEE

Patients' competence to manage their estates

The Act specifies that forthwith upon the admission of a patient to a psychiatric facility a physician *shall* examine the patient to determine whether or not he is competent to manage his estate. Physicians are also authorized to examine out-patients at any time for the same purpose.

If the physician believes the patient to be incompetent to do so, then a Certificate of Incompetence (Form 21) is completed. This Certificate is sent to the Public Trustee. The patient is also notified. The patient has the right to challenge this finding of incompetence before the Review Board once in any six-month period.

The Act requires the physician's determination as to competence to be entered by the physician in the clinical record together with written reasons.

This process also avoids, in some instances, the need for family members, or others, to proceed under *The Mental Incompetency Act* for the court appointment of a person called a "committee" to manage the estate of the patient.

Power of Attorney Act

This Act permits a person, when competent, to appoint someone (usually a relative) to handle their financial affairs should they become incompetent, even where the Public Trustee would usually have taken over the estate persuant to a Certificate of Incompetence.

When the Public Trustee becomes "committee"

The Public Trustee becomes committee of the estate of an in-patient or out-patient and assumes management of the estate on receiving a Certificate of Incompetence, on notice by the officer in charge or the attending physician of the existence of an emergency, or on receiving a voluntary appointment in writing, signed and sealed by an in-patient or out-patient appointing the Public Trustee as committee. The Public Trustee continues to serve as committee after discharge of the in-patient or out-patient on receipt of a Notice of Continuance (Form 24), which signifies that in the attending physician's opinion, the patient will not be competent to manage his or her affairs even after discharge from the psychiatric facility.

Rights and powers of the Public Trustee as committee

The Act permits the Public Trustee to exercise all the rights and powers over the person's estate that the person would have, if competent. The Public Trustee is account-

able to answer for his actions in regard to a person's estate.

When the Public Trustee ceases to be committee

The Public Trustee ceases to be committee of the estate of an in-patient or out-patient, and must relinquish management over the estate on receiving a Notice of Cancellation of the Certificate of Incompetence; on receiving revocation in writing of the appointment, signed and sealed by the in-patient or out-patient; on receiving Notice of Discharge of the in-patient or out-patient, unless he has received a Notice of Continuance; or on the expiration of six months following discharge of the in-patient or out-patient where a Notice of Continuance was received, (unless a court order extending the committeeship was obtained).

Examination of a patient before discharge

Where the Public Trustee is managing the estate, the attending physician must examine the in-patient or out-patient within 21 days before the person is discharged from a psychiatric facility, to determine whether this person will be competent to manage his or her estate on discharge. A Notice of Continuance is completed and sent to the Public Trustee if the person is still not competent.

Cancellation of certificate of incompetence

A physician may examine an incompetent patient at any time to determine whether or not the patient continues to be incompetent. Should the physician determine that the patient is no longer incompetent, a Notice of Cancellation of the Certificate of Incompetence (Form 23) will be issued by the physician, whereupon the Public Trustee will return to the patient the control of his or her estate.

Compensation

The Public Trustee may be allowed compensation "for services rendered" in an amount not greater than a trustee would be allowed for similar services.

In cases of poverty or hardship, however, the Public Trustee may agree to serve without compensation.

8. OFFENCES

Every person who contravenes any provision of this Act or the regulations is guilty of an offence and on summary conviction, is liable to a fine of not more than $10,000.

INDEX OF FORMS UNDER THE MENTAL HEALTH ACT

Form Number	Form Name	Corresponding Section of Act	Who Signs	When	Expiration Date
1	Application By Physician For Psychiatric Assessment	9	Any physician	Within seven days after the examination	Seven days after signed
2	Order For Examination	10	Justice of the Peace	No statutory time restriction	Seven days from and including the day it is made
3	Certificate Of Involuntary Admission	14(1)(c)	Attending physician (different than the physician who completed Form 1)	Before the expiration three days (72 hours) from time of admission of a patient for psychiatric assessment under section 9 or 26; at any time to change the status of an informal or voluntary patient (section 13)	Two weeks
4	Certificate Of Renewal	14(4)(b) 14(5)	Attending physician	Refer to section 14(4)(b)	Refer to Section 14(4)(b)
5	Change To Informal Or Voluntary Status	14(7)	Attending physician	Whenever deemed appropriate	N/A

6	Order For Attendance For Examination	15(1)	Judge	When person appears before him charged with or convicted of an offence	No statutory time restriction
7	Confirmation By Attending Physician Of Continued Involuntary Status Under Subsection 33f(1k) Of The Act	33f(1k)	Attending physician	After appeal to court of a review board decision is launched (refer to subsection 33f(1k) for details)	Refer to subsection 33f(1k)
8	Order For Admission	16(1)	Judge	When person in custody appears before Judge charged with an offence	No statutory time restriction on time within which order must be executed. Once executed, authorizes detention for up to two months.
9	Order For Return	22(1)(b)	Officer in charge of psychiatric facility	When the absence of a person who is subject to detention becomes known to the officer in charge (no order necessary for initial 24 hours)	One month after absence became known to officer in charge
10	Memorandum Of Transfer	23(1)	Officer in charge of psychiatric facility	At any time, under certain conditions	No statutory time restriction. If involuntary patients are transferred, detention is subject to limitations on certificates

Form Number	Form Name	Corresponding Section of Act	Who Signs	When	Expiration Date
11	Transfer To A Public Hospital	24(1)	Officer in charge of psychiatric facility	At any time, under certain conditions	No statutory time restriction. If involuntary patients are transferred, detention is subject to limitations on certificates
12	Warrant For Transfer From Ontario To Another Jurisdiction	25	Minister of Health	No statutory time restriction	No statutory time restriction
13	Order To Admit A Person Coming Into Ontario	26	Minister of Health	No statutory time restriction	No statutory time restriction on time within which order must be executed
14	Consent To The Disclosure, Transmittal Or Examination Of A Clinical Record under Section 29 Of The Act	29(3)(b)	Patient or person authorized to consent (section 1a)	No statutory time restriction	No statutory time restriction

15	Statement By Attending Physician Under Subsection 29(6) of The Act	29(6)	Attending physician	When disclosure required by Court or under an Act and certain conditions exist	No statutory time restriction
16	Application To Review Board Under Subsection 31(1) Of The Act	31(1)	Involuntary patient or anyone on his behalf; Minister of Health, Deputy Minister, officer in charge	Refer to section 31(2)	No statutory time restriction
17	Notice To Review Board	31(4)	Officer in charge of psychiatric facility	On completion of every fourth certificate of renewal	N/A
18	Application to Review Board Under Section 43 of The Act	43(1)	Patient or out-patient	Any time after certificate of incompetence or notice of continuance is issued (once in any six-month period)	No statutory time restriction
19	Application To Review Board Under Section 35a of The Act	35a	Attending physician	Any time after a patient has been found not mentally competent to consent to treatment (with restrictions as set out in section 35a)	No statutory time restriction

Form Number	Form Name	Corresponding Section of Act	Who Signs	When	Expiration Date
20	Statement In Support Of Application Under Section 35a Of The Act	35a	Attending physician and a psychiatrist who is not a member of the medical staff	Before the review board considers an application under section 35a	No statutory time restriction
21	Certificate Of Incompetence To Manage One's Estate	36(4)	The physician who performs an examination under section 36(1) or 36(2)	No statutory time restriction	Refer to sections 40, 42, and 43
22	Financial Statement	39	Responsible relative or friend	As soon as possible after the Public Trustee becomes committee of the estate of a patient or out-patient	N/A
23	Notice of Cancellation Of Certificate Of Incompetence To Manage One's Estate	40	Physician who performs the examination	No statutory time restriction	No statutory time restriction

24	Notice Of Continuance Of Certificate Of Incompetence To Manage One's Estate	41(2)	Physician who performs the examination in Section 41(1)	Any time from 21 days before the patient's discharge until the discharge	Six months following discharge
25	Application To Review Board Under Section 8a Of The Act	8a(1)	Child between 12 and 15 years of age inclusive	Right to apply once every 3 months	No statutory time restriction
26	Notice To Review Board Under Sub-section 8a(2) Of The Act	8a(2)	Officer in charge of psychiatric facility	Six months after admission if the child has not applied within the preceding six months	N/A
27	Notice By Officer In Charge To Informal Patient Under Subsections 30a(1b)(1e) And (2) of the Act	30a(1b) 30a(1e) 30a(2)	Officer in charge of psychiatric facility	Upon admission of informal patient between 12 and 15 years of age	N/A
28	Request To Examine Or To Copy Clinical Record Under Sub-sections 29a(2) And (16) Of The Act	29a(2) 29a(16)	Patient or person authorized to consent (section 1a)	No statutory time restriction	No statutory time restriction

Form Number	Form Name	Corresponding Section of Act	Who Signs	When	Expiration Date
29	Application To Review Board Under Subsection 29a(4) Of The Act	29a(4)	Officer in charge (on advice of attending physician)	Application must be made within seven days after the patient makes a request to examine or to copy the clinical record	N/A
30	Notice To Patient Under Subsections 30a(1) And (2) Of The Act	30a(1) 30a(2)	Attending physician	Upon completion of a certificate of involuntary admission (Form 3) or a certificate of renewal (Form 4)	N/A
31	Application To Review Board Under Subsection 29a(14) Of The Act	29a(14)	Patient	When a patient is determined or presumed to be not mentally competent to examine or to copy all or part of the clinical record or to authorize its disclosure	No statutory time restriction

32	Application To Review Board Under Subsection 35b(1) Of The Act	35b(1)	Patient	When a patient is determined or presumed to be not mentally competent to consent to psychiatric treatment and other related medical treatment	No statutory time restriction
33	Notice To Patient Under Subsections 30a(1a) and (2) Of The Act	30a(1a) 30a(2)	Physician who makes determination	When a physician determines that a patient is not mentally competent to (a) consent to treatment; (b) examine or authorize disclosure of his/her clinical record; or (c) manage his/her estate	N/A
34	Notice To Area Director Of Legal Aid Under Subsections	30a(1) 30a(1a) 30a(1c)	Attending physician	When a patient is notified in Form 30, 33 or 43	N/A
	30a(1), (1a), (1b) and (1c) of the Act	30a(1b)	Officer in charge	When a patient is notified in Form 27	
35	Application To Review Board To Extend Time Period For Conducting Or Completing A Review Of A Form 3 or A Form 4		Party before the review board	When more time is required for conducting or completing a review of a Form 3 or Form 4	No statutory time restriction

Form Number	Form Name	Corresponding Section of Act	Who Signs	When	Expiration Date
36	Notice Under Subsection 1b(4) Of The Act Of Right To Appoint A Representative	1b(4)	Attending physician	Within 48 hours of admission or registration as a patient	N/A
37	Application To Court Under Sub-section 33f(1c) Of The Act To Extend Time For Appeal	33f(1c)	Party before the court	When more time is required for conducting or completing an appeal from a decision of the review board	No statutory time restriction
38	Application To Court Under Sub-section 33f(1e) Of The Act To Extend Involuntary Certificate	33f(1e)	Party before the court (other than the patient)	When an involuntary certificate (or renewal or extension thereof) is likely to expire prior to the court hearing the appeal	No statutory time restriction
39	Physician's Certification Of Danger Under Subsection 35(2)(b)(iii) of the Act	35(2)(b)(iii) 35(3)	Treating physician	Before or shortly after giving such treatment as is necessary to preserve the life, limb or vital organ of the patient	N/A

40	NoticeTo Patient Of Right To Apply For A Representative Under Subsection 1c(2) Of The Act	1c(2)	Attending physician	As soon as practicable after the attending physician's determination that a patient is not mentally competent to appoint a representative	N/A
41	Application To Review Board To Appoint A Represent-ative Under Subsection 1c(1) Of The Act	1c(1)	Patient	At any time, with restrictions, after patient is found not mentally competent to appoint a representative	No statutory time restriction
42	Notice To Patient Under Subsection 30a(1c) Of The Act of Application for Psychiatric Assessment Under Section 9 or Section 26 Of The Act	30a(1c)	Attending physician	When an application for assessment under section 9 or an order under section 26 is executed	N/A
43	Notice To Patient Under Subsection 30a(1d) Of The Act Of Application For Treatment	30a(1d)	Attending physician	On application to the review board for an order authorizing the giving of specified psychiatric treatment and other related medical treatment, if any, to the patient	N/A

Form Number	Form Name	Corresponding Section of Act	Who Signs	When	Expiration Date
44	Appointment Of A Representative Under Subsection 1b(1) Of The Act	1b(1)	Person appointing a representative	No statutory time restriction	When revoked by the person who made the appointment or when the person appoints a new representative
45	Transitional Notice Under Subsection 1b(5) Of The Act Of Right To Appoint A Representative	1b(5)	Officer in charge of psychiatric facility	As soon as practicable after section 1b(5) comes into force on June 29, 1987	N/A

10. DEFINITIONS

"attending physician" — means the physician to whom responsibility for the observation, care and treatment of a patient has been assigned;

"clinical record" — means the clinical record compiled in a psychiatric facility in respect of a patient, and includes a part of a clinical record;

"Deputy Minister" — means the Deputy Minister of Health;

"electroconvulsive therapy" — means the procedure for the treatment of certain mental disorders that induces, by electrical stimulation of the brain, a series of generalized convulsions;

"informal patient" — means a person who is a patient in a psychiatric facility under the authority of a parent, guardian or committee of the person appointed for the patient under the *Mental Incompetency Act*;

"involuntary patient" — means a person who is detained in a psychiatric facility under a certificate of involuntary admission or a certificate of renewal;

"mental disorder" — means any disease or disability of the mind;

"mentally competent" — means having the ability to understand the subject-matter in respect of which consent is requested and able to appreciate the consequences of giving or withholding consent;

"Minister" — means the Minister of Health;

"Ministry" — means the Ministry of Health;

"officer in charge" — means the officer who is responsible for the administration and management of a psychiatric facility;

"out-patient" — means a person who is registered in a psychiatric facility for observation or treatment or both, but who is not admitted as a patient and is not the subject of an application for assessment;

"patient" — means a person who is under observation, care and treatment in a psychiatric facility;

"physician" — means a legally qualified medical practitioner;

"prescribed" — means prescribed by the regulations;

"psychiatric facility" — means a facility for the observation, care and treatment of persons suffering from mental disorder, and designated as such by the regulations;

"psychiatrist" — means a physician who holds a specialist's certificate in psychiatry issued by The Royal College of Physicians and Surgeons of Canada or equivalent qualification acceptable to the Minister;

"regulations" — means the regulations made under this Act;

"related medical treatment" — means medical treatment or procedures necessary for, the safe and effective administration of the psychiatric treatment or, the control of the unwanted effects of the psychiatric treatment;

"restrain" — means place under control when necessary to prevent serious bodily harm to the patient or to another person by the minimal use of such force, mechanical means or chemicals as is reasonable having regard to the physical and mental condition of the patient;

"review board" — means the review board appointed under section 30;

"senior physician" — means the physician responsible for the clinical services in a psychiatric facility.

[R.S.O. 1980 , c. 262, s. 1; 1986, c. 64, s. 33 (1-4); 1987, c. 37, s. 1.]

Ministry of Health

Ontario

ISBN 0-7729-3164-X
10M 9/90 REPRINT